BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MARIA CECELIA D. DIMAANO, M.D.** Holder of License No. 13509 For the Practice of Allopathic Medicine In the State of Arizona	Case No. MD-07-0844A **CONSENT AGREEMENT FOR LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Maria Cecelia D. Dimaano, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that she has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement or any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

DATED: 4-28-08

MARIA CECELIA D. DIMAANO, M.D.

DATED:

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 13509 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-07-0844A after receiving notification from a Medical Center that Respondent closed her practice on July 1, 2007 and resigned her privileges during an obstetrics/gynecology investigation of patient care and treatment. As a result of the investigation, the Board Staff reviewed two patients' medical records and found deviations in both records.

4. In June 2007, an obstetric patient, MM, presented to the hospital for an assessment. Hospital staff noted MM had a fever when she first presented. Hospital staff contacted Respondent and she requested an assessment in triage. Following the assessment, staff made numerous calls to Respondent; however, she did not respond until two hours later. Respondent verbally ordered a urinalysis, complete blood count and acetaminophen. Hospital staff again made numerous attempts to contact Respondent. Respondent did not respond until an hour later and verbally discharged MM. There was no documentation that Respondent presented to the hospital and physically evaluated MM.

5. On February 19, 2007 at 9:15 p.m., patient LH was admitted for induction as she was past her due date. Following her admission, staff contacted Respondent. Respondent verbally ordered Cervidil. Hospital staff administered Cervidil and LH's labor progressed. On February 20, 2007, LH was examined by staff and found to be 1.5 cm dilated. Hospital staff successfully reached Respondent at 7:30 a.m. and reported variable decelerations. At 6:00 p.m., staff again notified Respondent and requested an on-site evaluation of LH. At 6:30 p.m., Respondent examined LH and ordered a cesarean section

(C-section) as LH's labor did not progress. At 7:40 p.m., Respondent successfully carried out the C-section. LH was monitored by nursing staff post-partum without complications and was discharged on February 22, 2007. There was no documentation that Respondent evaluated LH prior to February 20, 2007 at 6:30 p.m., indicating Respondent did not physically present to the hospital to evaluate LH following her induction.

6. While providing care for patients in the hospital the standard of care requires a physician to be readily available and respond to calls from the staff in a timely manner regarding the care required.

7. Respondent deviated from the standard of care because she was not readily available for MM and she did not timely respond to calls from the staff in regards to MM's care required.

8. The standard of care requires a physician to evaluate hospitalized patients on a regular basis, to assess their status and to maintain ongoing care.

9. Respondent deviated from the standard of care because she was not available for LH following induction and she did not see her until thirty-three hours after admission.

10. If complications had developed in the case of patient MM and Respondent was not available, fetal or maternal distress could have occurred without immediate ability to evaluate and treat appropriately.

11. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because there

was no documentation that Respondent physically presented to the hospital to evaluate MM and LH.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.") and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failure to be readily available and respond to hospital staff in a timely manner and for failure to maintain adequate records.

2. This Order is the final disposition of case number MD-07-0844A.

DATED AND EFFECTIVE this 5TH day of JUNE, 2008.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed
this 5th day of June 2008 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 5th day of June, 2008 to:

Maria Cecelia D. Dimaano, M.D.
Address of Record

Investigational Review